BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **RAMACHANDRA N. RAO, M.D.** Holder of License No. **25615** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-06-0293A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 7, 2007. Ramachandra N. Rao, M.D., ("Respondent") appeared before the Board with legal counsel Gordon Lewis for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 25615 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0293A after receiving a complaint regarding Respondent's care and treatment of a seventy-eight year-old female patient ("LS") alleging Respondent failed to diagnose and properly treat pneumonia, low potassium levels, and congestive heart failure. LS presented to Respondent, her primary care physician, on July 25, 2005 with vague complaints of shortness of breath, tiredness, constipation, and weakness. Respondent took LS's vital signs and noted an elevated blood pressure, LS's lungs sounded congested, and she was wheezing. Respondent's medical record contains a check mark in the space for a neurological examination, but there are no other notes related to such an examination. Respondent performed a pulmonary function study that indicated low functioning

and he initiated a nebulizer treatment for the wheezing. LS vomited once during the treatment. After the treatment, Respondent performed another pulmonary function study and LS's function improved. Respondent prescribed Biaxin and Prednisone for bronchitis and Upper Respiratory Infection ("URI"). Respondent's final diagnosis was URI, constipation, bronchitis, weakness and acute bronchospasms. Respondent arranged for LS to follow-up in his office on July 27, 2005.

4. On July 27, 2005 LS's family found her on the floor of her home confused and unable to stand. Medics transported LS to Banner Hospital where she was admitted with the diagnosis of severe hyponatremia, hypokalemia, pneumonia, and rhabdomyolysis from the fall. An EKG demonstrated some ST changes consistent with ischemia and hypokalemia. A head CT was negative. LS was treated in the intensive care unit, responded well to treatment, and was discharged four days later.

5. Respondent was aware at LS's July 25 visit that a coronary angiogram showed normal coronary arteries and that she had cardiac catheterization that showed significant aortic incompetence rated 2 plus that resulted in a strain pattern on the EKG. Respondent did not order additional EKGs because repeated EKG's prior to and after the July 25 visit have shown the same pattern and he believed repeated EKGs would not have assisted in his diagnosis of LS.

6. Respondent believed LS's blood pressure was balanced and she suffered no chest pains and was well compensated during her time under his care. Respondent was aware prior to LS's July 25 visit that x-rays and CT scans of her chest showed emphysematous changes, scarring in both lungs, and moderate size hiatal hernia, therefore, he believed x-rays for LS would be very difficult to interpret. Respondent believed that the burden of treating a chest infection rested on the clinician and not on radiological support.

7. Respondent is board-certified in internal medicine and his current practice is an office practice, but he has hospital privileges. Respondent would approach a twenty-eight year-old patient who is complaining of cough and shortness of breath differently than he would a

seventy-eight year-old patient with the same complaints because the younger patient is less likely to have co-morbid conditions and may have lungs that do not have long-term pathological changes. As a result, Respondent would take a more comprehensive approach with a patient with more co-morbidities. LS had multiple co-morbidities. Respondent documented a chief complaint of weakness and tiredness, nausea, constipation, and shortness of breath. Respondent did not ask LS about chest pain on the July 25 visit because LS was well known to him and he believed there was no issue regarding chest pain on this visit. However, Respondent did not ask the question and an outside reviewer or other physician reviewing the chart would not know there was no issue involving chest pain because LS was not asked and Respondent did not document that it was not an issue.

8. Other causes of chest pain besides ischemia Respondent might have addressed in LS's July 25 visit include possibility of pneumothorax, bronchospasm causing chest tightness, possible pulmonary embolism, musculoskeletal chest pain, and pneumonia, if it is causing pleurisy. Respondent follows the "SOAP" format (subjective, objective, assessment and plan) in his charts and believes it is not standard to do a review of systems on all visits subsequent to the first visit. As part of Respondent's training and experience in internal medicine a respiratory rate was part of the vital signs he would commonly take on an elderly patient with acute shortness of breath. The respiratory rate should have been in the chart and Respondent has discussed this extensively with his staff to make sure all vital signs are written in the chart. LS's temperature was also a required vital sign. Pneumonia was not one of Respondent's diagnoses for LS and he believed it would be hard on a radiological basis to say whether she had pneumonia or not, especially with the chronic lung changes she had. It was important to know whether or not LS had pneumonia. To determine whether or not LS had pneumonia Respondent started her on antibiotics and asked her to come back in forty-eight hours. If LS had worsened, Respondent would have proceeded to look into the matter further.

9. A pulmonary embolism is always a possibility, but given the circumstances (LS was ambulant, was at home, there was no hemoptysis and no prolific chest pain), Respondent did not place it high on the list for LS. Respondent did not document anything about chest pain. Respondent documented only pertinent positives LS presented with. The check marks in particular boxes on Respondent's chart for LS mean that he did examine for these things and did not find either any positive signs or pertinent negative signs. On an October 14, 2005 visit where he saw LS immediately postoperative for a right cataract removal, his chart where an examination of "head, eyes, ears, nose and throat" ("HEENT") are marked, is checked "normal." Respondent indicated the "normal" was for all items except the eyes. Respondent had earlier said if he did not find either positive signs or pertinent negative signs he put check marks on the chart, but he was now claiming the check mark meant everything but the eyes were normal. Respondent also documented LS's earlier HEENT examinations as normal, but LS had a cataract.

10. When LS collapsed on July 27, 2005 she had a sodium of 103 – a significant hyponatremia. The conditions that might prompt Respondent to think about electrolyte abnormality in a seventy-eight year-old woman with aortic insufficiency, hypertension and morbid obesity would be lethargy, stuporousness, muscle weakness, dehydrated appearance, and tachycardia disproportionate to her condition, if she had a history of fluid loss. Respondent noted edematous patients tend to be volume-expanded, but if they have gastrointestinal loss or loss through the skin, he would have to consider volume loss. Based on what Respondent noted in LS's chart it is not clear whether LS was volume expanded or volume depleted. Respondent did not have a history of vomiting for LS or history of fluid loss. Respondent did not believe the small amount of vomitus LS had during the nebulizer treatment put her over the threshold.

11. The symptoms of hypokalemia include muscular weakness usually limited to the striated muscle and LS expressed her weakness to Respondent in general terms. Respondent admitted that a patient would not generally present complaining of being weak "in their striated

muscle" and would just say they feel weak, but he would expect a patient to say they have weakness in a particular place and LS's complaint was that she felt weak. LS was on multiple medications, was weak, nauseated, and vomited during the nebulizer treatment, but Respondent did not believe it warranted obtaining lab work on that particular occasion. Respondent was considering it and that is why he wanted to see LS in forty-eight hours or for her to call him if there was any deterioration. Although Respondent's note says LS had aortic stenosis she actually had aortic regurgitation graded as two plus. Respondent's chart said "aortic stenosis" because LS told him she had aortic stenosis, but when he reviewed an earlier chart of LS's from another physician, it said "aortic regurgitation." LS's symptoms were also symptoms of hypokalemia. According to Respondent a patient with hypokalemia or significant hyponatremia would not have been able to walk into his office unassisted, sit across the table from him, have a conversation regarding her medications, and go into the next room and get the nebulizer treatment. There is a difference between acute onset hyponatremia and gradual onset hyponatremia. Gradual onset hyponatremia could present with very slow development of symptoms. LS never had hyponatremia in the past and Respondent claimed it would have been very hard for him to anticipate her becoming hyponatremic because early hyponatremia does not present with any clear symptoms.

12. The standard of care required Respondent to consider and document a complete history of present illness and an appropriate review of systems for the presenting complaint and conduct appropriate further evaluation where indicated.

13. Respondent deviated from the standard of care because he did not consider the complexity of LS's complaints of her present illness and her current medications, because he failed to do a review of systems, and failed to conduct appropriate further evaluation where indicated.

14. LS's hypokalemia and hyponatremia progressed over the forty-eight hours after she saw Respondent and the electrolyte imbalance led to LS's collapse and subsequent rhabdomyolysis from the fall and she required fairly aggressive treatment in the hospital to return her sodium levels to an acceptable level.

15. A physician is required to maintain adequate medical records. An adequate medical record means a legible record containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records do not meet this standard.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); and A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for failure to appropriately assess a patient and for inadequate medical records.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 30th day of April 2007.

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 30th day of April, 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Mail this
30th day of April, 2007, to:

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